THE CANCER LETTER

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SENATE SUBCOMMITTEE AGREES ON $1.188 BILLION NCI BUDGET FOR FY 1985, $110 MILLION INCREASE OVER '84

The Senate Labor-HHS Appropriations Subcommittee overlooked the tradition of waiting until the House acts on money bills and approved a whopping increase of more than $110 million for NCI in the 1985 fiscal year over its current year budget. The total approved by the subcommittee of $1.188 billion was $86.6 million more than

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In Brief

ORGAN SYSTEMS COORDINATING CENTER DECISION STILL DELAYED; BRANCH MERGED WITH DCPC CENTERS BRANCH

ORGAN SYSTEMS coordinating center controversy remained on hold this week as NCI Director Vincent DeVita continued to delay final decision on who will get the award—Roswell Park Memorial Institute, as the National Cancer Advisory Board has recommended, or the Univ. of Texas Graduate School of Biomedical Sciences at Galveston. Meanwhile, NCI's Div. of Cancer Cause & Prevention has decided to merge the Organ Systems Branch into the Cancer Centers Branch. DCPC Director Peter Greenwald announced at last week's meeting of the Assn. of American Cancer Institutes that Organ Systems would be a section within the Centers Branch. The reason, as explained by Jerome Yates, head of DCPC's Centers & Community Oncology Program: "The Organ Systems Program is essentially an RO1 program, with research along disease oriented lines. There is an overlap of investigators at centers, with common directed programmatic research cutting across departmental lines. We are in the process of moving centers into a more active area, using the task force approach in taking results from basic research to applied research. We hope to develop collaborative efforts between centers and the Organ Systems Program. We think it will strengthen both programs." The new branch, which will still be called the Centers Branch, will have three main activities—management of center core grants, the task force activities which overlap centers and organ systems, and the Organ Systems Program.... **NCI STAFF** members who received 1984 NIH Director's Awards: Gerald Crabtree, senior investigator, Laboratory of Pathology, Div. of Cancer Biology & Diagnosis; Susan Hubbard, chief of the Scientific Information Branch; and Flora Grantham, lab technician in the Laboratory of Pathophysiology, DCBD. NIH Commendation Medals went to Paul Bunn, head of the Cell Kinetics Section of the NCI-Navy Medical Oncology Branch, Div. of Cancer Treatment; Lance Liotta, chief of the Laboratory of Pathology, DCBD; Clarence Fortner, special assistant to the chief of the Investigational Drug Branch, DCT; and Daniel Ihde, head of the Clinical Investigations Section, NCI-Navy Medical Oncology Branch.

SENATE WOULD GIVE NCI CLOSE TO TOTAL AMOUNT ASKED IN 1985 BYPASS BUDGET

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requested in the President's budget and, for the second straight year, approximately equalled the amount asked in NCI's bypass budget.

The bypass budget for FY 1985, submitted to the White House a year ago, asked $1.189 billion.

The Senate subcommittee's counterpart in the House was prevented from taking up the Labor-HHS appropriations bill earlier by the two week long debate in the House over the immigration bill. William Natcher (D.-Ky.), chairman of the House Labor-HHS Appropriations Subcommittee, chaired the debate on the immigration measure and was unable to call a meeting of the subcommittee during that time.

The House traditionally acts first on appropriations bills. In the case of NIH appropriations, the Senate invariably adds substantially to the House amounts. Whether that will happen in reverse remains to be seen. The Natcher subcommittee was tentatively scheduled for its markup of the bill this week.

If NCI ends up getting the full amount approved by the Senate subcommittee, chaired by Lowell Weicker (R.-Conn.), this would be the impact:

*The priority score payline for most grants would be lifted from about 170 estimated in the President's budget to about 190.

*All grants, including cancer centers and cooperative groups, would be funded at close to their peer review recommended levels.

*The budget for construction grants would be increased from $1 million to $6.6 million.

*An amount of $7.6 million would be earmarked to support six new clinical trials.

*Support for training grants, career development awards, and intramural research would be increased.

*Funds would be directed to support at least one new cancer center.

In an unusual but not unprecedented action, the bill's report directs that $4.5 million be used to initiate development of a cancer center at the Univ. of West Virginia. Sen. Robert Byrd of West Virginia is the Senate minority leader and second ranking Democrat on the subcommittee and parent Appropriations Committee.

Similar directives have turned up in the past in committee reports on behalf of the Norris Cotton Cancer Center (named for a former member of the subcommittee), Harvard, Georgetown and others.

Timothy Talbot, chairman of the board of directors of the Assn. of American Cancer Institutes, has carried that group's message to the various congressional committees this year. One of the results is this statement in the Senate committee report:

"The Committee has provided an additional $12,410,000 over the Administration's request for NCI research centers. This amount would support one additional center, for a total of 60, and restore close to full estimated costs for research centers in 1985. Cancer center core grants are essential for the stability and continued excellence of cancer centers and directly enhance the effectiveness of research grants at the centers. The Committee is aware that during the past year such core grants have been treated differently from other grants and have been decreased on the average of 15 percent below the peer review levels, and desires that these core grants be funded at full peer review levels."

Byrd's influence undoubtedly accounts for the next paragraph in the report:

"The Committee has received information concerning the Appalachian region's need for a state of the art cancer center in West Virginia. It has been estimated that about one third of those West Virginians dying from cancer might have been saved by earlier diagnosis and treatment. The lack of organized statewide approaches to cancer prevention, detection and accessibility to specialized care underscores the need for an academically based cancer program for the state of West Virginia and the region of Appalachia that it would serve. The Committee directs that $4.5 million be used to facilitate the development of a cancer center at the Univ. of West Virginia."

On clinical trials:

"The Committee has provided $7,590,000 to enable NCI to support six new clinical trials in fiscal year 1985. These trials would explore high priority topics in such areas as uncommon but treatable cancers, regional limb perfusion of chemotherapy, immunotherapy in high risk colon cancer, and therapeutic trials of monoclonal antibodies."

On construction:

"The Committee is aware that the Construction Subcommittee of the National Cancer Advisory Board evaluated construction needs and concluded that needs for NCI construction support are far higher than indicated. In addition, the Committee understands that the chairman of the President's Cancer Panel is joining with the American Cancer Society to fund a survey to measure overall cancer construction needs. The Committee directs that a report of the survey findings be presented before the fiscal year 1986 budget hearings. In addition, the Committee has provided NCI with $6.6 million as a modest beginning toward the rehabilitation of the Institute's extramural facilities. In addition,

these funds may be used in conjunction with funds provided for cancer centers to augment the startup costs of the West Virginia Cancer Center."

Sen. Daniel Inouye (D.-Hawaii), a member of the subcommittee, may have had something to do with this portion of the report:

"The Committee remains concerned that the National Cancer Institute give a high priority to addressing the extraordinary incidence of cancer among Native Hawaiian peoples. The Department's own figures indicate that Native Hawaiians have the highest incidence of any people in our nation. The Committee is aware of the Institute's efforts to date to encourage quality research applications in this area and encourages NCI to continue to give this matter priority."

More on clinical trials:

"The Committee supports NCI's expanded clinical trials program carried on largely through the clinical cooperative groups. This program has yielded results that are now reflected nationwide in improving survival rates. In 1900, for example, cancer was considered incurable. Since that time, survival rates have consistently increased until today the percent of all cancers in the U.S. that are curable approximates 50 percent. The Committee is pleased that NCI's training program has seeded the country with trained cancer specialists."

On research training and career development:

"The Committee notes that while the National Academy of Sciences indicates that the strong demand for research scientists in the biomedical and clinical sciences will continue, the number of trainees funded by NIH in recent years has declined. The Committee wishes to reverse this trend and has provided an increase of $8.3 million over the Administration's request to NCI for its research training program so that additional trainees may be supported and that stipends may be increased to be more competitive with other predoctoral and post-doctoral training programs.

"The Committee also recognizes the important career development opportunities provided to research investigators through the research career program. The Committee has, therefore, provided an additional $450,000 to NCI for the support of additional research career awards."

On intramural research and management support:

"The Committee has included $192.9 million for the Institute's intramural research program. The increase of $7.7 million over the President's budget request will fully fund mandatory cost increases and restore enough full time equivalent position reductions to enable the Institute to continue these important research activities at approximately the 1984 program level. The amount provided will also enable the Institute to support a modest increase in research activity above the current operating level.

"The Committee's allowance of $59.4 million for NCI's research management and support activities would fund mandatory cost increases and restore enough full time equivalent position reductions to provide current services for these activities in 1985."

On prevention:

"The Committee recommends further development of preventive programs and is pleased at NCI's other major thrust in reducing cancer deaths by 50 percent within the next 16 years. Two major prevention components have been identified: smoking and diet. NCI aims at saving 75,000 lives a year through reduced smoking, and another 20,000 through improved diet, including informing Americans about the importance of more fiber and less fat. . . The Committee believes there is a clear and pressing need to improve public awareness of the role individuals can play in preventing cancer deaths. Accordingly, the Committee recommends NCI give even greater priority to its role of educating the nation about the relationship between lifestyle and cancer and to pursue initiatives which will be targeted toward improving prevention."

The report expressed support for the proposal to establish Year 2000 goals. It will be in consideration of the appropriations bills next year when the extent of congressional commitment to those goals is really tested. The FY 1986 bypass budget asks for nearly $1.5 billion—$300 million above the Senate figure for 1985—with most of the increase requested for programs needed to meet the goals.

The committee report also expressed support for PDQ, NCI's computer based system to provide state of the art treatment and referral information to physicians; the SEER program which tracks and monitors incidence and survival and documents progress; and the series of meetings by the President's Cancer Panel around the country to assess cancer center needs, "including geographical distributions and responsiveness to the needs of minority populations. We will be interested in pursuing the results of this effort at next year's hearing."

The subcommittee recommended $5.164 billion for the overall NIH budget, an increase of $688 million over 1984 and $597 million more than requested by the White House.

"The Committee continues to be exceptionally concerned with the Administration's approach to the NIH budget," the report says. "The Committee notes that the Administration's overall budget request calls for a 14 percent increase in research spending, the largest increases going to the Depts.

of Defense and Energy but with the National Science Foundation slated for a 13.6 percent increase as well. By contrast, only a two percent increase is requested for NIH. That level of funding would severely reduce the number of approved research projects; require significant cuts in direct costs for all project grants; reduce the amount of research that would be performed by our scientists; ignore the need for continued training opportunities that serve to attract the keenest young minds in America to biomedical research; severely handicap ongoing clinical trials and leave some 40 new clinical trials unfunded. The Administration's budget request totally ignores deteriorating research facilities and the shortfalls and obsolescence in scientific instrumentation and equipment. And, in addition, it calls for the elimination of 588 positions. . .

"The Committee recognizes that our nation's efforts in biomedical research have resulted in our citizens living longer and healthier lives than ever before. Now is certainly not the time to cut back on our support, particularly in light of recent advances in new medical technologies, molecular biology, monoclonal antibodies, recombinant DNA, and many other areas of research now bearing fruit in terms of improved health and better survival rates from major diseases."

As it did with the NCI budget, the subcommittee noted that its recommendation "provides for full costs at historical levels for research grants, research centers, and ongoing clinical trials" throughout NIH. Noting that congressional directives stopped the practice of funding grants at less than peer review approved levels, the report said "the Committee believes that such arbitrary reductions are unwise. The Committee therefore recommends sufficient funds to enable NIH to pay, on the average, about 97 percent of study section recommended levels for new and competing renewal projects and about 99 percent of noncompeting continuation projects.

"The Committee is disturbed by the decline over recent years in NIH average award rates and paylines. In 1979 NIH received sufficient resources to fund almost 52 percent of all eligible applications for new and competing renewal research project grants. The average priority score or payline was approximately 240. The Administration's 1985 budget request for NIH, however, would permit only 31 percent of all eligible applications to be funded and would entail an average priority score or payline of barely over 170 (Ed. note: that may not read precisely as intended. The payline was estimated at 170, not the average priority score of funded grants). The Committee believes that this downward trend must be reversed and has provided funds to increase the minimum payline for each NIH institute to at least 190. This will fund approximately an additional 1,800 new and competing renewal research project grants and at an additional $216 million.

"Intramural programs and research management are also funded at nearly full cost, including restoration of 500 of the 588 full time equivalent positions which would otherwise be eliminated by the Administration's budget request. . .

"The Committee strongly disapproves the proposal to collect $7.5 million in reimbursements for 'nonresearch related services' provided to patients participating in research protocols at the clinical center. Such a scheme would harm the research activity of NIH since it would discourage participation in research protocols. Moreover, given all the legislative changes needed and the negotiations with insurance carriers which must be conducted before such a program can be put in place, there is little possibility that such a reimbursement program could be operational for 1985." The subcommittee added $7.5 million to the appropriation to cover the amount the White House had said would be collected from patients.

Other institutes benefitted from the subcommittee's recognition of the problem of research facilities needs:

"The Committee finds increasing evidence that the nation's health research facilities are slowly deteriorating and that the great need for a new federal construction program to replace outmoded facilities, relieve overcrowding, and accomodate changing research requirements must be addressed. Of particular need are new facilities for dealing with toxic wastes and with laboratory animals as well as major renovations and repairs for many existing facilities. There is also serious need for a current study of facilities needs. For these purposes the Committee has provided funds to initiate a modest beginning under the extramural construction and renovation authorities of the National Cancer Institute, National Heart, Lung & Blood Institute, and the National Eye Institute, with $6.6 million going to each Institute. In addition, the Committee directs the director of NIH to submit a proposal for the participation of NIH in a long term plan designed to modernize and rehabilitate the national biomedical research physical plant and scientific apparatus."

The report in its section on NCI makes it clear that RO1s, PO1s and center core grants are to be fully funded. Less clear is the intent for cooperative groups. Given NIH's history of interpreting full funding directives in the narrowest sense, it might seen that the door is still open to once again funding groups at less than recommended levels. However, the section of the report dealing with NIH

in general seems to make the committee's intent clear:

"The Committee's budget recommendation provides for full costs, at historical levels, for research grants, research centers, and ongoing clinical trials."

DCT BOARD OKAYS RECOMPETITION OF COP DATA MANAGEMENT CONTRACT

The Board of Scientific Counselors of NCI's Div. of Cancer Treatment gave concept approval to the recompetition of a clinical data management contract by the Clinical Oncology Program at the Board's meeting earlier this month.

The Board also approved a request by COP to negotiate an expansion of a contract awarded by the Div. of Cancer Etiology to the Univ. of the West Indies in Jamaica to permit collaboration on human T-cell leukemia virus research.

The clinical data management contract currently is held by Orkand Corp. It will be recompeted for a five year period at an estimated annual cost of $350,000. Staff description of the work performed:

This contractual effort has been in place since 1972 under the direction of the Biostatistics & Data Management Section, the statistical component of the Clinical Oncology Program. The general objectives of this section are to conduct statistical studies of clinical and preclinical data, and to provide data management and data processing support relevant to identifying improved cancer therapies. The contract has continued through several recompetitions to the present time. Working in government provided space within the NIH clinical center, contract staff work directly with COP investigators, helping them to define data collection requirements and develop data collection instruments. The contractor develops, documents and maintains the software necessary to support the various data bases of COP; provides data collection and data management capabilities as required; and responds to the other data processing requirements of the COP branches as directed by the project officer.

Major accomplishments of the clinical data management project include:

1. The Cancer Patient Research Information (CAPRI) system was designed, developed, and is being enhanced and maintained by contract staff. This generalized file management software system provides a means for collecting, storing, and retrieving essential baseline and treatment related data on all patients being treated by the COP branches. Contract staff assist in the collection of data for this system, continue to develop data collection forms as required by government personnel, and perform frequent ad hoc retrievals and provide summary reports of data currently stored on the CAPRI data base. To date, more than 25,000 forms are stored in the data base, reflecting over 5,000 different patients.

2. Operations office and/or statistical office support has been provided for a number of multi-institutional clinical trials in which one or more of the COP branches are participating. This support includes such activities as producing randomization materials and performing randomizations; monitoring patient eligibility and data submissions; visual editing of all data submitted; developing and maintaining system software, and updating of study data base; producing regularly scheduled status reports, ad hoc reports, and tabulations as required for group meetings or interim analyses. Multi-institutional studies supported include protocols in early stage ovarian cancer with the Ovarian Cancer Study Group and Gynecologic Oncology Group; the NCI/Childrens Cancer Study Group protocol for acute lymphoblastic leukemia; the NCI/CCSG protocol for poor prognosis acute lymphoblastic leukemia; and the Washington Myeloma Group study.

3. Contract staff has recently developed and implemented a system for regularly collecting and reporting on chemotherapy related toxicity data entered into the clinical center's Medical Information System (MIS). A monthly summary report is produced and distributed to all senior investigators responsible for protocols on which patient toxicity information is registered, ensuring that toxicity is monitored in a systematic and regular manner

4. Individual contract staff members have been assigned to provide specialized support to a number of COP branches. This support includes general data management support to the Pediatric Branch, including maintenance of the branch's census file of patients being followed both on and off therapy, collection of followup data on branch patients, and response to tumor registry requests; development and maintenance of the Medicine Branch census file of patients being followed both on and off therapy; data management support to the NCI-Navy Medical Oncology Branch, including the assignment of one staff member to work on site at Bethesda Naval Hospital one day each week; and specialized programming and retrieval support to the researchers of the Surgery Branch.

5. Contract staff has continued to work closely with statisticians and other researchers of the COP, to determine and develop methodologies and procedures which are responsive to the data management needs and interests of the program. This has included adapting existing systems and approaches to data processing to respond to changing needs, such as the growing requirement for data management support in administrative areas, as well as an ongoing assessment of technological changes in the data processing environment which can be used to meet the growing needs and interests of the researchers.

Future plans for the clinical data management project are to continue in its present role, providing ongoing data management and data processing support under the direction, and in support of the statistical efforts of the Biostatistics & Data Management Section. The extent and description of this support is dynamic and is defined through efforts of COP researchers and statisticians.

DCE BOARD APPROVES CONCEPT OF THREE STUDIES IN RADIATION EPIDEMIOLOGY

Three sources sought announcements released this week by NCI for radiation epidemiology studies (see below) were derived from concepts approved earlier this month by the Board of Scientific Counselors of the Div. of Cancer Etiology.

DCE staff anticipated that all three would involve noncompetitive awards to Scandinavian institutions, but federal procurement regulations required that efforts be made to determine if other organizations may be capable of doing the studies. If so, the awards will be competed through RFPs.

The three projects are:

Cancer in the opposite breast following radiotherapy for primary breast cancer. Estimated cost, $70,000 per year, four years. NCI believes that the Danish Cancer Registry, with Ole Jensen as principal investigator, is the only organization that can meet the requirement for 1,000 long term survivors with a second breast cancer.

Prenatal x-ray exposure and childhood cancer in twins. Estimated cost, $50,000 per year for three years. NCI said the Swedish Institute of Environmental Medicine, with Nancy Pedersen the PI, is the only organization it knows which can meet the requirements.

Thyroid cancer risk following diagnostic and therapeutic exposure. Estimated cost, $390,000 over four years. The proposal would use the records of Radiumhemmet, Karolinska Institute. Lars-Erik Holm is the principal investigator.

RFPs AVAILABLE

Requests for proposal described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. NCI listings will show the phone number of the Contracting Officer or Contract Specialist who will respond to questions. Address requests for NCI RFPs, citing the RFP number, to the individual named, the Blair building room number shown, National Cancer Institute, NIH, Bethesda, MD. 20205. Proposals may be hand delivered to the Blair building, 8300 Colesville Rd., Silver Spring, Md., but the U.S. Postal Service will not deliver there. RFP announcements from other agencies will include the complete mailing address at the end of each.

SOURCES SOUGHT

RFP NCI-CP-EBP-41032-77

Title: Cancer in the opposite breast following radiotherapy for breast cancer

Deadline for statement of capabilities: Aug. 3

The Radiation Epidemiology Branch of NCI is planning a collaborative case control study of women with breast cancer who developed a second malignancy in the opposite breast 10 or more years after initial treatment. The risk of second breast cancer after pre or postoperative radiotherapy for the initial cancer will be evaluated in terms of dose to the contralateral breast. Respondents to this announcement must document the following:

1. Existence of a large, geographically defined population based tumor registry with a high level of cancer ascertainment which has existed for at least 25 years. This registry must be able to identify on the order of 50,000 women who were diagnosed with breast cancer. Approximately 80 percent of this population must be over 40 years of age.

2. Existence of at least 1,000 women who developed a second primary breast tumor in the opposite breast at least 10 years after the first breast malignancy.

3. Existence of a comparison group of 1,000 women among the 10 or more year survivors who did not develop a second malignancy in the opposite breast. The sample must provide controls who can be matched to cases on age at diagnosis, calendar year of diagnosis and survival past the date of the second cancer diagnosis of the case.

4. Availability of medical and treatment records for this population so that information can be photocopied and abstracted on details of radiotherapy treatments as well as on known breast cancer risk factors.

5. Evidence of staff qualifications in the area of cancer epidemiology.

6. Availability of consultant physicists to evaluate radiotherapy records.

7. Indication of ability and willingness of the respondent to engage in collaborative research with members of the Radiation Epidemiology Branch of NCI.

A brief response to the announcement should include: (a) a description of the population based cancer registry (how long it has been in operation, how complete the ascertainment is); (b) a description of the identified breast cancer population (total number of breast cancers, number of women who survived 10 or more years after initial cancer diagnosis—a minimum of 1,000 must be available for study), number of women who developed a second primary in the opposite breast 10 or more years after diagnosis of initial breast cancer, age of the population at time of diagnosis of initial breast cancer; (c) description of information available in the medical records regarding radiotherapy and breast cancer risk factors; (d) staff qualifications in cancer epidemiology, including any previous experience in the conduct of similar studies.

Respondents must meet all of the requirements listed above. Submit ten copies of the resume of experience and capabilities.

Contract Specialist: Patrick Williams
RCB Blair Bldg Rm 114
301-427-8888

RFP NCI-CP-EBP-41033-77

Title: Prenatal x-ray exposure in twins and childhood cancer

Deadline for statement of capabilities: Aug. 3

NCI proposes a case control study of childhood cancer in relation to prenatal x-ray exposure of twin pregnancies. Purpose is to evaluate the relative risk of childhood cancer among the in utero exposed compared to the nonexposed in population based cohorts of twins in a defined geographic area and covering the years of birth 1935-1967, when radiographic procedures were often carried out in twin pregnancies. About 100 cases of neoplasia with onset before age 16 years should be identified by screening more than 85,000 twin individuals in the above defined cohorts through national death and cancer incidence reporting systems.

Potential contractors must supply evidence that the source used for casefinding will identify approximately 100 cancer deaths or registrations with onset under 16 years of age among twins. Sufficient information on diagnosis must be available to evaluate type of malignancy and onset age. Sampling source must provide at least four potential controls for each case, matched on sex, year of birth and surviving past the date of death of the matching case, if deceased. Contractors will show that medical records pertaining to delivery and postnatal care of the twins and to radiologic procedures during the twin pregnancy are adequate to meet objectives of this study and that contractors possess competence for processing and evaluating the data collaboratively with the NCI project officer.

Organizations must document the following capabilities:

1. Evidence of access to at least 85,000 twin individuals born 1935-1967 whom they can follow through a national or regional reporting system for mortality during 1950-1979 to obtain death certificate information, and for cancer morbidity during 1958-1980, to obtain information on diagnosis and treatment.

2. Accurate description of the demographic characteristics of the base twin population screened for cancer, and evidence that the screening will detect approximately 100 cases of childhood cancer with onset under 16 years of age.

3. Detailed description of the work that will be performed to recover obstetric, pediatric and radiologic records pertaining to the twin birth for the cancer cases and for a matched group of several controls per case, with evidence that these records consistently contain information on any x-ray procedures carried out during the twin pregnancy, the date of the mother's last menstrual period prior to delivery, and birthweight of the twins.

4. Evidence of staff qualifications in epidemiology and computer processing of large data files.

5. Indication of ability to carry out collaborative research with scientists in biomedical disciplines located outside of their organizational framework.

Respondents must meet all of the requirements listed above.

Submit 10 copies of the resumes and statements of capabilities.

Contract Specialist: Patrick Williams
RCB Blair Bldg Rm 114
301-427-8888

RFP NCI-CP-FS-41031-77
Title: Thyroid cancer following diagnostic and therapeutic 131-1 exposure
Deadline for statement of capabilities: July 12

The Radiation Epidemiology Branch of the Epidemiology & Biostatistics Program of NCI's Div. of Cancer Etiology is seeking to identify patient populations exposed to diagnostic and therapeutic radioactive iodine (131-1) in order to conduct a collaborative retrospective cohort study of cancer risk. Respondents must document the following:

1. The existence of at least 40,000 persons administered diagnostic 131-1 prior to 1971. At least five percent of these patients must be less than 20 years of age at time of first 131-1 exposure.

2. The existence of at least 20,000 persons treated by 131-1 for hyperthyroidism, thyroid cancer, or cardiovascular disease prior to 1976.

3. Both the diagnostic and therapeutic 131-1 patient rosters should be identified from the same hospital sources.

4. The availability of medical and treatment records so that information can be abstracted on 131-1 exposure (number of milli or microcuries administered, estimated thyroid gland mass, 131-1 uptake over time), reason 131-1 was administered, discharge diagnoses, and subsequent treatments.

5. Existence of a geographically defined, population based tumor registry with a high level of cancer ascertainment that completely covers the catchment area from which cancers in the exposed cohorts would be reported. Cases of cancer occurring in the exposed cohorts will be identified through record linkage with the tumor registry, which must have been in existence for at least 25 years.

6. The existence of a death registration system so causes of death among persons in the exposed cohorts can be identified through record linkage with this system. The death registration systems must have been in existence during the entire study period (1950-1983) and should completely cover the catchment area from which deaths in the exposed cohorts would be recorded.

7. Evidence of staff qualifications in cancer epidemiology and experience in conducting followup studies of populations exposed to radionuclides.

8. Indication of willingness of respondent to engage in collaborative research with members of the Radiation Epidemiology Branch.

A brief response should include: (1) description of the exposed populations (numbers of patients, ages at diagnosis or treatment, calendar years of diagnostic 131-1 exposure or treatment; (2) description of information contained in the medical records including information on 131-1 exposure necessary to conduct dosimetric studies of thyroid gland doses; (3) description of the population based cancer registry including how complete ascertainment is, how long it has been in operation, and previous experience in conducting record linkage studies with the registry; (4) description of the death registration system; (5) staff qualifications in cancer epidemiology and experience on conducting followup studies of populations exposed to radionuclides.

Respondents must meet all of the requirements of this announcement. Submit ten copies of resumes and statements of capabilities.

Contract Specialist: Patrick Williams
RCB Blair Bldg Rm 114
301-427-8888

NCI ADVISORY GROUP, OTHER CANCER MEETINGS FOR JULY, AUGUST, FUTURE

Hyperthermic Oncology--July 2-6, Aarhus, Denmark. Fourth international symposium. Contact Dr. Jens Overgaard, Symposium Chairman, Institute of Cancer Research, Radiumstationen, DK-8000 Aarhus C., Denmark.

Cancer Control Grant Review Committee--July 9, NIH Bldg 31 Rm 8, open 8:30-9 a.m.

Medical Screening & Biological Monitoring for the Effects of Exposure in the Workplace--July 10-13, Clarion Hotel, Cincinnati. Sponsored by NIOSH, NCI, EPA. Contact Jenny Watson, Conference Coordinator, Technical Resources Inc., Suite 408, 10215 Fernwood Rd., Bethesda, Md. 20817.

Cancer Regional Studies Review Committee--July 12-13, NIH Bldg 31 Rm 9, open July 12 8:30-9 a.m.

Clinical Cancer Program Project Review Committee--July 16-17, Bethesda Marriott Hotel, open July 16 8:30-10 a.m.

Cancer Preclinical Program Project Review Committee--July 17-18, NIH Bldg 31 Rm 10, open July 17 9-9:30 a.m.

International Cancer Conference--July 17-19, Bogota, Colombia. Contact J. Ospina, Instituto Nacional de Cancerologia, Calle la 9-85, Bogota.

International Conference on Head & Neck Cancer--July 22-27, Baltimore. Contact Program of Continuing Education, Univ. of Maryland School of Medicine, 10 South Pine St., Baltimore 21201.

American Society for Virology--July 22-26, Madison, Wisc. Third annual meeting, concurrent international symposium on pox/iridoviruses and on arenaviruses. Contact Dr. David Bishop, ASV secretary-treasurer, Dept. of Microbiology, LSCR 520 11th St. South, Univ. of Alabama, Birmingham 35294.

Clinical Trials Committee--July 23-25, NIH Bldg 31 Rm 9, open July 23 9-9:30 a.m.

Biometry & Epidemiology Contract Review Committee--July 26-27, NIH Bldg 31 Rm 7, open July 26 9-9:30 a.m.

Advanced Seminars in Dermatology--Aug. 1-5, Incline Village (Lake Tahoe), Nev. Contact Office of Continuing Medical Education, School of Medicine TB 150, Univ. of California, Davis 95616.

Second Terry Fox Cancer Conference--Aug. 2-4, Vancouver, B.C. Contact Univ. of British Columbia, Dept. of Anatomy, 2177 Wesbrook Mall, Vancouver V6T 1W5, Canada.

Cancer Therapeutics Program Project Review Committee--Aug. 6-7, NIH Bldg 31 Rm 8, open Aug. 6 8:30-9 a.m.

Rocky Mountain Cancer Conference--Aug. 9-11, Fairmont Hotel, Denver. 38th annual conference for medical professionals. Contact Chris Heminway, RN, 303-758-2030, or American Cancer Society, 2255 S. Oneida, Denver 80224.

International Society for Experimental Hematology--Aug. 12-16, Atlanta. 13th annual meeting. Contact Dr. Ralph Vogler, Meeting Chairman, Emory Univ., Woodruff Bldg Rm 718, Atlanta 30322, phone 404-329-5830.

Florida Tumor Registrars Assn.--Aug. 15-17, High Q Quality Inn, Orlando. Annual workshop. Contact American Cancer Society, Florida Div., Tampa.

Electrophoresis Society--Aug. 27-31, Gottingen, West Germany. 4th international meeting. Contact Prof. Dr. Volker Neuhoff, Max-Planck Institut fur Experimentelle Medizine, Hermann-Rein Strasse 3, D-3400 Gottingen.

Statistical Methods in Environmental Risk Assessment--Aug. 30-31, Kyoto, Japan. Contact Dr. Barry Margolin, National Institute of Environmental Health Sciences, Statistics & Biomathematics Branch, PO Box 12233, Research Triangle Park, N.C. 27709, phone 919-541-3460.

FUTURE MEETINGS

American Institute of Ultrasound in Medicine--Sept. 16-19, Kansas City. 29th annual meeting. Contact AIUM, 4405 East-West Highway, Suite 504, Bethesda, Md. 20814, phone 301-656-6117.

Assn. of Community Cancer Centers--Sept. 28-29, Portland, Ore. Regional meeting. Contact Comprehensive Cancer Program, Good Samaritan Hospital & Medical Center, 1015 NW 22nd Ave., Portland 97210, phone 503-229-7283.

Genetics, Cell Differentiation & Cancer--Oct. 8-9, New York City. 7th annual Bristol-Myers Symposium on Cancer Research. Organized by Memorial Sloan-Kettering Cancer Center. Contact Suzanne Emery, MSKCC, 425 E. 61st St., New York 10021, phone 212-794-7173.

Assn. of Community Cancer Centers--Oct. 9-13, Broadmoor Hotel, Colorado Springs. Midyear meeting, "Oncology Economics 1984," followed by ACCC clinical session. Contact Elm Services, 11600 Nebel St., Rockville, Md. 20852, phone 301-984-1242.

Challenge of 1984: Practical Approaches to Quality Care--Oct. 12-14, Waterville Valley, N.H. Contact Linda O'Connor, RN, Baystate Medical Center, 759 Chestnut St., Springfield, Mass. 01199, phone 413-787-3368.

NCI CONTRACT AWARDS

TITLE: Epidemiologic study of black/white differences in cancer patient survival experience
CONTRACTOR: Louisiana State Univ. Medical Center, $499,501.

The Cancer Letter _Editor Jerry D. Boyd

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